Appendix H

Glossary

GLOSSARY

1. **STPA (Single Administrator):** The party to an employee benefit plan that may collect premiums, pay claims, develop provider networks, and provide administrative services. Examples include: Aetna, Blue Cross, Blue Shield, Buck Consultants, Cigna, George Michael & Associates, Healthnet, Humana, Kaiser and United Healthcare.

2. **Self-Insured:** Arrangements in which the total responsibility for providing plan benefits remains with the employer. All financial risk resides with the employer.

3. **Capitaion (HMO):** Capitation benefit program is one in which a provider contracts with the employer to provide all or most of the services covered to subscribers on a per capita basis. This capitation fee is fixed regardless of the actual number or nature of services provided to subscribers in a given time. Capitation is often used in HMO programs to pay primary care and specialty physician services.

4. **Medical Management:** The practice of managing medical costs and risk through effective business practices.

5. **Health and disease management:** A proactive approach to managing individuals who have or are at risk of developing chronic conditions. The approach involves education and prevention initiatives, monitoring techniques, patient self-care and evidence based clinical practice guidelines to improve health outcomes and health care costs.

6. **Prescription drug management:** Refers either to an individual or to a company that manages pharmacy benefits, including development of formularies and drug utilization review to help control costs. An example is step therapy or pre-authorization requirement.

7. **Claims administration:** An entity that reviews and determines whether to pay claims to enrollees or health care providers on behalf of the health benefit plan. Claims administers can include insurance companies and their designated claims review organizations, self-insured employers, third party administrator or other private contractors.

8. **Narrow provider and hospital networks:** A network with a restricted panel of providers whose selection into the network is based on a mixture of performance and price metrics. Narrow networks often are less costly due to relative network efficiency compared to a standard network.

9. **Risk selection:** Is the practice of setting rates and premiums based on the risk level of the individuals who are to be insured. Should we say anti-selection? Anti-selection: The result of better health risks choosing a lower cost benefit program. The result is the sicker (more costly) population accelerates cost increases in the more expensive benefit program.

10. **Risk pool:** The population of individuals across which costs for services are spread; the experience of the population (“pool”) is used to develop rates.

11. **Transparency:** Transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services, so they can make informed choices among doctors and hospitals.